TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Marvin E. Van Hal, M.D.

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-15-3243-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… consider this a request for payment."

Amount in Dispute: $175.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier contends the Requestor's treatment for which recovery is sought was neither reasonable nor necessary nor related to the compensable injury."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 17, 2014	Evaluation & Management, established patient (99214)	$175.00	$168.90

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursing professional medical services.
4. 28 Texas Administrative Code §137.100 defines the treatment guidelines adopted by the Division of Workers' Compensation.
5. 28 Texas Administrative Code §19.2003 provides definitions for terms related to utilization reviews.
6. 28 Texas Administrative Code §19.2009 sets out the procedures for notices of determination of utilization reviews.

7. 28 Texas Administrative Code §19.2010 provides the requirements prior to issuing adverse determinations of utilization review.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 203 – Peer review has determined – payment for treatment has not been recommended due to the lack of medical necessity. Peer review has provided its findings to the provider in prior documentation.
   - 216 – Based on the findings of a review organization.

Issues

1. Does an unresolved extent of injury issue exist for this dispute?
2. Did the insurance carrier appropriately raise medical necessity for this dispute?
3. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier asserts in its position statement that "Three of the four ICD-9 codes [listed on the bill] are not related to the compensable injury … To the extent these non-compensable conditions were the subject of … treatment, the charges for the treatment are not related to the accepted or adjudicated injury."

   28 Texas Administrative Code §133.307 (d)(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Review of the submitted documentation does not support that an extent of injury issue was introduced for the disputed services prior to the date the request for MFDR was filed with the division. Therefore, this issue will not be considered.

2. The insurance carrier denied disputed services with claim adjustment reason code "216 – Based on the findings of a review organization," and "203 – Peer review has determined – payment for treatment has not been recommended due to the lack of medical necessity. Peer review has provided its findings to the provider in prior documentation."

   28 Texas Administrative Code §137.100 (e) states, "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Retrospective utilization review is defined in 28 Texas Administrative Code §19.2003 (b)(31) as, "A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted." The insurance carrier provided a document dated August 12, 2013 to support a medical necessity denial. However, this date is prior to the date of service and does not meet the requirements of §19.2003 (b)(31) for retrospective review.

   In addition, 28 Texas Administrative Code §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

   Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute.

3. 28 Texas Administrative Code §134.203 (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1)

Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." Further, 28 Texas Administrative Code §134.203 (c) states, in relevant part, "…Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The conversion factor for date of services September 17, 2014 is $55.75.

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 1.521. The practice expense (PE) RVU of 1.41 multiplied by the PE GPCI of 1.013 is 1.42833. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.803 is 0.0803. The sum of 3.02963 is multiplied by the Division conversion factor of $55.75 for a MAR of $168.90.

4. The total MAR for the disputed services is $168.90. The insurance carrier paid $0.00. Therefore, a reimbursement of $168.90 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $168.90.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $168.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	August 13, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.